

Shielding Proposal

Instructions: Please fill out the form below, print and fax to Bio-Med Associates at: 908-788-6757

Date _____ Name _____ Facility _____
Address 1 _____ Address 2 _____

I am pleased to present you with this proposal for Radiological/Health Physics services, regarding Shielding Requirements and Radiation Protection Survey of your equipment for **(Facility Name)**.

The calculations for the shielding report will be made in accordance with the recommendations of the National Council on Radiation Protection, and in accord with regulations of the State of New Jersey. Approximately three man-hours will be needed to complete the shielding requirements for each room. Any changes regarding the location of equipment, barriers, or the occupancy of all adjacent areas, will necessitate recalculation of the barrier specifications.

The fee for this service is \$190.00 per hour. An invoice along with color coded sketch of the barrier specifications will be presented following service, payment must be received within 30 days from receipt of invoice. Upon receipt of payment, the final processed report will be mailed.

After completion of the room and installation of the equipment Bio-Med Associates will perform a Radiation Protection Survey and performance evaluation on your equipment in full compliance with all State and FDA regulations. This will assure that the equipment complies with all radiation safety regulations, and equipment performance specifications and regulations. Measurements of radiation levels will be made inside and outside the room (if necessary), as well as measurements of all regulated machine parameters including kVp, mAs, focal spot size, radiation output, collimator alignment, phototimer reproducibility, etc.

General radiographic equipment can usually be completed in four hours; multiple tubes will require additional time. This estimate includes the medical physics requirement specified in the contract. To establish a new QA program an additional two to four hours may be required, depending on the level of training required by your staff. Please review the attached QA equipment you will need to implement the program. Please contact us if you have questions. A Copy of the most recent radiation protections survey must be available for review. Additional visits may be necessary if the equipment is not available during the physicist's visit. A QA Manual with written procedures and sample forms will be provided with acceptance of this proposal. Patient dosimetry measurements and calculations are optionally available upon request.

The fee for this service is \$1-0.00 per hour. There is a three hour minimum for site visits. Routine service is 9 a.m. to 5 p.m., however, other times are available upon request. The physicist will prepare a handwritten, unofficial report during each visit and leave you a photocopy. An invoice will be presented following service, payment must be received within 30 days from receipt of invoice. Upon receipt of payment, a final processed report will be mailed.

Payments made thirty days past the due date are subject to 1 1/2% per month finance charge. Accounts over ninety days will be considered delinquent. If collection becomes necessary, **(Ck bYf#79C)** will be responsible for all collection costs, interest from the date the account becomes delinquent, and a minimum of 25% attorney fees.

You will be advised of the date and time of each of the physicist's visits. If this needs to be changed, please provide two weeks notice. Cancellations are subject to a 3 hour fee.

In addition, **(Facility)** agrees not to solicit or hire any employee or individual under contract with Bio-Med Associates, Inc., at any time for any service without written permission from Bio-Med Associates, Inc.

Please sign below and fax or mail at your earliest convenience to schedule service. This proposal is valid for 60 days.

Thank you for the opportunity of presenting this proposal. If I can be of further assistance, please feel free to contact me.

Sincerely,
BIO-MED ASSOCIATES, INC.

Jack J. Merkin, M.S.
President

Accepted by: _____, (Please sign here)

Title: _____ Date: _____ P.O. _____ Phone #: _____